PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2021-D26

PROVIDER-
Oswego Hospital

Provider No.: 33-0218

vs.

MEDICARE CONTRACTOR –
National Government Services, Inc.

RECORD HEARING DATE –
February 1, 2021

Cost Reporting Period Ended –
12/31/2011

CASE NO. – 17-0849

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ISSUE STATEMENT

Whether the Medicare Contractor properly calculated the Revised Volume Decrease Adjustment ("VDA") owed to the Provider for the significant decrease in inpatient discharges that occurred in its cost reporting period ending December 31, 2011 ("FY 2011"), and whether the Medicare Contractor properly reopened the Original VDA approval.[1]

DECISION

After considering the Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor properly reopened the Original VDA approval but improperly recalculated the VDA payment for FY 2011 for Oswego Hospital ("Oswego" or "Provider"), and that Oswego should receive an additional $1,144,213, for a total VDA payment in the amount of $2,306,489 for FY 2011.

INTRODUCTION

Oswego is a non-profit acute care hospital located in Oswego, New York. Oswego was designated as a Sole Community Hospital ("SCH") during the fiscal year at issue.[2] The Medicare contractor[3] assigned to Oswego is National Government Services, Inc. ("Medicare Contractor"). In order to compensate it for a decrease in inpatient discharges, Oswego requested an original VDA payment of $2,271,866 for FY 2011.[4] On February 25, 2013, the Medicare Contractor originally calculated Oswego's FY 2011 VDA payment to be $2,956,089.[5] The Medicare Contractor notified Oswego on February 5, 2016 that it was reopening the original VDA approval based on directions from the Center for Medicare and Medicaid Services ("CMS").[6] By letter dated July 22, 2016, the Medicare Contractor issued the Revised VDA Approval in the amount of $1,162,276, requiring a repayment by Oswego in the amount of $1,793,813.[7] Oswego timely appealed the Medicare Contractor's revised VDA approval and met all jurisdictional requirements for a hearing before the Board.

The parties requested and the Board approved a record hearing on February 1, 2021. Oswego was represented by William H. Stiles, Esq. of Verrill Dana, LLP. The Medicare Contractor was represented by Scott Berends, Esq. of Federal Specialized Services.

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[1] Revised Stipulations at ¶18 (hereinafter "Stipulations").
[2] Stipulations at ¶ 1.
[3] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate and relevant.
[4] Medicare Contractor's Final Position Paper at 6 (hereinafter "Medicare Contractor's FPP"). *See also* Exhibit C-1.
[5] Exhibit P-3.
[6] Exhibit P-4.
[7] Exhibit P-5.

STATEMENT OF FACTS AND RELEVANT LAW

Medicare pays certain hospitals a predetermined, standardized amount per discharge under the inpatient prospective payment system ("IPPS") based on the diagnosis-related group ("DRG") assigned to the patient. These DRG payments are also subject to certain payment adjustments. One of these payment adjustments is referred to as a VDA payment and it is available to SCHs if, due to circumstances beyond their control, they incur a decrease in the total number of inpatient cases of more than 5 percent from one cost reporting year to the next.[8] VDA payments are designed to compensate a hospital for the fixed costs that it incurs for providing inpatient hospital services in the period covered by the VDA, including the reasonable cost of maintaining necessary core staff and services.[9] The implementing regulations, located at 42 C.F.R. § 412.92(e) reflect these statutory requirements.

It is undisputed that Oswego experienced a decrease in its total number of inpatient cases greater than 5 percent from FY 2010 to FY 2011 due to circumstances beyond its control and, as a result, was eligible to have a VDA calculation performed for FY 2011.[10] Oswego requested a VDA payment in the amount of $2,271,866 for FY 2011.[11] The Medicare Contractor initially agreed with Oswego and determined that Oswego was entitled to a VDA payment of $2,956,089.[12] The Medicare Contractor then revised the VDA calculation to $1,162,276, necessitating a repayment of $1,793,813 by Oswego, after removing variable costs, based on direction from CMS.[13]

42 C.F.R. § 412.92(e) (2011) directs how the Medicare Contractor must adjudicate the VDA once an SCH demonstrates it experienced a qualifying decrease in its total number of inpatient cases. In pertinent part, § 412.92(e)(3) states:

> (3) The intermediary determines a lump sum adjustment amount *not to exceed*[14] the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs . . . .
>
> (i) In determining the adjustment amount, the Intermediary considers— . . .
>
> (B) The hospital's fixed (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter. . . .

In the preamble to the final rule published on August 18, 2006,[15] CMS referenced the Provider

[8] 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[9] *Id*.
[10] Stipulations at ¶ 10.
[11] Exhibit P-2.
[12] Exhibit P-3.
[13] Exhibit P-5.
[14] (Emphasis added.)
[15] 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).

Reimbursement Manual, Pub. No. 15-1 ("PRM 15-1") § 2810.1 (Rev. 356), which provides further guidance related to VDAs and states in relevant part:

> B. Additional payment is made . . . for the fixed costs it incurs in the period in providing inpatient hospital services including the reasonable cost of maintaining necessary core staff and services, not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue.
>
> Fixed costs are those costs over which management has no control. Most truly fixed costs, such as rent, interest, and depreciation, are capital-related costs and are paid on a reasonable cost basis, regardless of volume. Variable costs, on the other hand, are those costs for items and services that vary *directly*[16] with utilization such as food and laundry costs.

The chart below depicts how the Medicare Contractor and Oswegor each calculated the VDA payment leading to this appeal.

	Medicare Contractor REVISED calculation using fixed costs[17]	Provider/PRM calculation using total costs[18]
a) Prior Year Medicare Inpatient Operating Costs	$16,384,752	$16,280,621
b) IPPS update factor	1.0235	1.022366
c) Prior year Updated Operating Costs (a x b)	$16,769,794	$16,644,753
d) FY 2011 Operating Costs	$15,682,265	$15,543,916
e) Lower of c or d	$15,682,265	$15,543,916
f) DRG/MDH payment	$13,155,990	$13,272,050
g) CAP (d-f)	$ 2,526,275	$ 2,271,866
h) FY 2011 Inpatient Operating Costs	$15,682,265	$15,543,916
i) Fixed Cost percent	91.30	1.00[19]
j) FY 2014 Fixed Costs (h x i)	$14,318,266	$15,543,916
k) Total DRG/SCH Payments	$13,155,990	$13,272,050
l) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount by which line j exceeds linek)	$ 1,162,276	
m) VDA Payment Amount (Oswego's VDA is based on the amount by which line d exceeds line f.)		$2,271,866

[16] (Emphasis added.)
[17] Exhibit C-3 at 2.
[18] Exhibit P-2 at 12.
[19] *See* Provider's Final Position Paper (hereinafter "Provider's FPP") at 10-11. Oswego asserts that PRM § 2810.1 and the Federal Register for FFY 2007 and FFY 2009 make no mention of a removal of variable costs from the Provider's Operating Costs. As a result, the Fixed Cost Percentage is reported as 1.00.

The parties to this appeal dispute the application of the statute and regulation used to calculate the VDA payment.[20] Variances between the two calculations in the Prior Year Inpatient Operating Costs and DRG Payment are noted above. The table calculations reflect the final position papers; however, it is further noted by the Board that the amounts in the Medicare Contractor's Calculation were agreed upon in the Stipulations at ¶ 21.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

Oswego states that, after the Medicare Contractor reviewed Oswego's VDA Request and any supplemental responses, it determined that Oswego's VDA Request satisfied the applicable statute, regulation and CMS program instructions. Accordingly, it approved Oswego's VDA Request and issued its Original VDA Approval in the amount of $2,956,089.[21]

Oswego asserts that the Medicare Contractor's methodology for determining the Original VDA Approval was consistent with the approach that it had consistently utilized (and reported to CMS) for over 25 years. In addition, the Medicare Contractor's original approach was compliant with the plain language of the applicable statute, regulation, and CMS program instructions. Accordingly, Oswego did not appeal the Original VDA Approval, as permitted pursuant to 42 U.S.C § 1395oo.[22]

By letter dated February 5, 2016, the Medicare Contractor notified Oswego that it was revising the original VDA.[23] Oswego objected to the reopening. Notwithstanding, by letter dated July 22, 2016, the Medicare Contractor issued the Revised VDA Approval in the amount of $1,162,276.[24] This resulted in Oswego being required to repay $1,793,813 to the Medicare Contractor.[25]

Oswego maintains that the workpapers attached to the Medicare Contractor's Revised VDA Approval demonstrate that the Medicare Contractor applied a new methodology that was inconsistent with the plain language of the applicable statute, regulation and CMS program instructions.[26]

Oswego claims that CMS' revised VDA approval methodology runs afoul of the notice and comment rulemaking requirements of the Administrative Procedure Act ("APA")[27] and the Medicare program at 42 U.S.C. § 1395hh(a).[28] They argue that CMS and/or the Medicare Contractor violated the APA by making a substantive change in the VDA calculation

[20] Stipulations at ¶ 17.
[21] Exhibit P-3.
[22] Provider's FPP at 3.
[23] Exhibit P-4.
[24] Exhibit P-5.
[25] *Id.*
[26] Provider's FPP at 4.
[27] 5 U.S.C. Ch. 5.
[28] Provider's FPP at 17.

methodology that produces a significant effect on private interests; namely, it substantially reduces the amount of VDA payments due to providers.[29] Further, they argue that, although CMS may be entitled to revise its interpretation of the VDA statute, such a drastic departure from its previous interpretation amounts to a substantive rule triggering the requirements of notice and comment rulemaking.[30] Oswego states that, even if the revised VDA Approval Methodology does not amount to an improper substantive rule under the APA, the Supreme Court's recent decision in *Azar v. Allina Health Services* ("*Allina*")[31] makes clear that the revisions violate the notice and comment rulemaking requirements at 42 U.S.C. § 1395hh(a) which, the Board notes, specifies, in pertinent part, that "[n]o rule, requirement or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment for services . . . shall take effect unless it is promulgated by regulation under paragraph (1)."

In support of its position, Oswego asserts that the examples given at PRM 15-2810.1 detail exactly how the Medicare Contractor is required to determine the VDA payment, and that CMS and/or the Medicare Contractor improperly departed from this methodology. However, the Board notes that these examples relate to the cap and not the actual VDA calculation, as the Eighth Circuit recently confirmed in *Unity HealthCare v. Azar*:

> The hospitals' main argument to the contrary relies on the premise that the Manual's sample calculations unambiguously conflict with the Secretary's interpretation and that the Secretary is bound by the Manual as incorporated via later regulations. The hospitals point out that the Secretary has previously stated that [PRM 15-1] § 2810.1(B) of the Manual, where the examples are located, contains "the process for determining the amount of the volume decrease adjustment." See 71 Fed. Reg. 47,870, 48,056 (Aug. 19, 2006). However, the examples are not presented in isolation. The same section of the Manual reiterates that the volume-decrease adjustment is "not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue." In a decision interpreting § 2810.1(B) immediately following the Secretary's guidance, *the Board found "that the examples are intended to demonstrate* ***how to calculate the adjustment limit*** as opposed to determining which costs should be included in the adjustment." See Greenwood Cty. Hosp v. BlueCross BlueShield Ass'n, No. 2006-D43, 2006 WL 3050893, at *9 n.19 (P.R.R.B. Aug. 29, 2006). That decision was not reviewed by the Secretary and therefore became a final agency action. The agency's conclusion that the examples are meant to display the ceiling for a VDA, rather than its total amount, is a reasonable interpretation of the regulation's use of "not to exceed," rather than

[29] *Id.* at 24.
[30] *Id.*
[31] 139 S. Ct. 1804 (2020).

> "equal to," when describing the formula. *We conclude that the Secretary's interpretation was **not** arbitrary or capricious and was consistent with the regulation.*[32]

Accordingly, what Oswego points to as written or published CMS "policy" on how to calculate the VDA payment was not, in fact, such a policy.

Moreover, the fact that the Medicare Contractor may have previously calculated VDAs differently does not automatically mean there is a departure from a Medicare program "policy."[33] The Board notes that the D.C. Circuit has confirmed that substantive Medicare reimbursement policy can be adopted through case-by-case adjudication.[34] This is different than the situation discussed by the Supreme Court in *Allina*,where a new substantive reimbursement policy was announced on the CMS website and was applied nationwide to all hospitals at one time.[35] The fact that CMS may have directed the Medicare Contractor to calculate the VDA differently *in this particular case* (or even on a case-by-case basis, as presented to CMS) is not inconsistent with adopting a substantive policy through adjudication, and is different than the *Allina* situation where CMS posted publicly on its website a "nationwide" adoption of new substantive policy. Indeed, the Board notes that VDA calculations, by their very nature, are provider specific and subject to appeal, as delineated at 42 C.F.R. § 412.92(e)(3).[36] Moreover, the Board has had long standing disagreements with Medicare contractors and the Administrator on their different interpretations and application of the relevant statutes, regulations and Manual guidance regarding the calculation of VDAs.[37] Accordingly, the Board rejects Oswego's APA and *Allina* arguments.

The Medicare Contractor states that CMS directed it to revise Owsego's original VDA approval to remove variable costs.[38] Oswego argues that this reopening did not comply with 42 C.F.R. § 405.1885(c) as it did not provide "explicit notice that the Original VDA Approval is inconsistent with applicable law, regulations, CMS ruling, or other interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS in effect, and as CMS understood those legal provisions, at the time the determination or

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[32] 918 F.3d 571, 578-79 (8th Cir. 2019) (footnotes omitted; bold and italics emphasis added).
[33] Moreover, the fact that this particular Medicare contractor historically calculated VDAs in a particular manner does not make that CMS policy.
[34] *See, e.g., Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914 (D.C. Cir. 2013).
[35] 139 S. Ct. at 1808, 1810.
[36] This regulation specifies that the Medicare contractor "considers" three hospital specific factors "[i]n determining the [volume decrease] adjustment amount" and that this "determination is subject to review under subpart R of part 405 of this chapter."
[37] *See, e.g.*, *Unity Healthcare v. Blue Cross Blue Shield Association*, PRRB Dec. No. 2014-D15 (July 10, 2014); *Halifax Regional Medical Center v. Palmetto GBA*, PRRB Dec. No. 2020-D1 (Jan. 31, 2020). Similarly, Oswego fails to give any examples or support to its position that CMS and/or the Medicare Contractor are substantively changing policy as it relates to determining which costs are "treated" as variable versus semi-fixed in accordance with PRM 15-1 § 2810.1. *See, e.g.*, Provider's FPP at 26. Further, the application of the PRM definitions of these terms to a particular provider's VDA request seems to be the very nature of adjudicatory fact-finding and why providers may appeal Medicare contractor VDA determinations to the Board.
[38] Exhibit P-4 at 3.

decision was rendered by the contractor."[39] As a result, Oswego argues that the reopening should therefore be deemed invalid, and the revised VDA calculation deemed "void."[40]

The Medicare Contractor argues that it has the authority to reopen and revise a final determination under its own discretion pursuant to 42 C.F.R. § 405.1885(a) which states:

> *(a) General.* (1) A Secretary determination, a contractor determination, or a decision by a reviewing entity (as described in § 405.1801(a)) may be reopened with respect to specific findings on matters at issue in a determination or decision by CMS (with respect to Secretary determinations), **by the contractor (with respect to contractor determinations)**, or by the reviewing entity that made the decision… [41]

The Medicare Contractor engaged in discussions with CMS regarding the inclusion of variable expenses in its Final VDA calculation and the need to recalculate the VDA payment amount to remove these costs. Based on these discussions, the Medicare Contractor determined that variable expenses needed to be reviewed and removed from the Final VDA Determination calculation. [42] The Medicare Contractor notified Oswego of this review and recalculation of the Final VDA payment determination in its February 5, 2016, letter to Oswego.[43]

The Medicare Contractor asserts that it was bound to revise the VDA payment to remove the variable expenses, in accordance with the plain language of the relevant statute and regulation, Social Security Act § 1886(d)(5)(D)(ii) and 42 C.F.R. § 412.92(e) and that it was authorized to make the revision to the Final VDA payment under its own discretion in accordance with 42 C.F.R. § 405.1885(a).[44]

The Medicare Contractor issued the original VDA approval on February 25, 2013 and the Notice of Reopening was dated December 8, 2015, in compliance with 42 C.F.R. § 405.1885(b)(1), which states "An own motion reopening is timely only if the notice of intent to reopen (as described in § 405.1887) is sent no later than 3 years after the date of the determination of decision that is subject to the reopening." Accordingly, the Board finds that the Medicare Contractor had the authority to revise the VDA determination.

In addition, Oswego contends that the Medicare Contractor's approach does not fully compensate the hospital for its fixed and semi-fixed operating costs, and argues that the revised calculation of the VDA was incorrect because the methodology used by the Medicare Contractor guarantees that a hospital will never receive full compensation for its fixed costs.[45] According to

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[39] Provider's FPP at 13.
[40] *Id* at 14.
[41] (Bold emphasis added.)
[42] Medicare Contractor's FPP at 9.
[43] *Id*.
[44] *Id*.
[45] Provider's FPP at 28.

Oswego, the Medicare Contractor's Revised VDA improperly treated fixed (and semi-fixed) costs as variable costs, and confused inpatient and outpatient expenses.[46] Oswego reasons that, if variable costs are to be excluded from inpatient operating costs when calculating the VDA, there should also be a corresponding decrease to the DRG payment for variable costs. This method, Oswego maintains, would assure an accurate matching of revenue with expenses, because the DRG payment is intended to cover both fixed *and* variable costs. Oswego also references the fact that CMS essentially adopted this approach when it prospectively changed the final rule for calculating VDA payments, starting in FFY 2018.[47]

The Board notes that there is a difference in the FY 2011 Inpatient Operating Costs used by the parties in calculating the VDA payment. The Medicare Contractor calculated an adjusted amount of Inpatient Operating Costs to account for variable costs on the cost report. Oswego argues that the Medicare Contractor's VDA calculation methodology violates the statutes, regulations, and PRM instructions.[48]

In its recent decisions,[49] the Board has disagreed with the methodology used by various Medicare contractors to calculate VDA payments because that methodology compares fixed costs to total DRG payments and only results in a VDA payment if the fixed costs exceed the total DRG payment amount. In these cases, the Board has recalculated the hospitals' VDA payments by estimating the fixed portion of the hospital's DRG payments (based on the hospital's fixed cost percentage as determined by the Medicare contractor), and comparing this fixed portion of the DRG payment to the hospital's fixed operating costs, so there is an apples-to-apples comparison.

The Administrator has overturned these Board decisions, stating:

> [T]he Board attempted to remove the portion of DRG payments the Board attributed to variable costs from the IPPS/DRG revenue. . . . In doing so the Board created a "fixed cost percentage" which does not have any source of authority pursuant to CMS guidance, regulations or underlying purpose of the VDA amount. . . . The VDA is not intended to be used as a payment or compensation mechanisms that allow providers to be made whole from variable costs, i.e., costs over which providers do have control and are relative to utilization. The means to determine if the provider has

[46] *Id*. at 11.
[47] *Id.* at 29-30.
[48] *Id.* at 28.
[49] *St. Anthony Reg'l Hosp. v. Wisconsin Physicians Servs.*, PRRB Dec. No. 2016-D16 (Aug. 29, 2016), *modified by*, Adm'r Dec. (Oct. 3, 2016); *Trinity Reg'l Med. Ctr. v. Wisconsin Physicians Servs.*, PRRB Dec. No. 2017-D1 (Dec. 15, 2016), *modified by*, Adm'r Dec. (Feb. 9, 2017); *Fairbanks Mem'l Hosp. v. Wisconsin Physicians Servs.*, PRRB Dec. No. 2015-D11 (June 9, 2015), *modified by*, Adm'r Dec. (Aug. 5, 2015).

> been fully compensated for fixed costs is to compare fixed costs to the total compensation made to the provider . . . .[50]

Recently, the Circuit Court for the Eigth Circuit ("Eighth Circuit") upheld the Administrator's methodology in *Unity*, stating the "Secretary's interpretation was not arbitrary or capricious and was consistent with the regulation."[51]

At the outset, the Board notes that the CMS Administrator decisions are not binding precedent, as explained by PRM 15-1 § 2927.C.6.e:

> e. Nonprecedential Nature of the Administrator's Review Decision.—Decisions by the Administrator ***are not precedents*** for application to other cases. A decision by the Administrator may, however, be examined and an administrative judgment made as to whether it should be given application beyond the individual case in which it was rendered. If it has application beyond the particular provider, the substance of the decision will, as appropriate, be published as a regulation, HCFA Ruling, manual instruction, or any combination thereof so that the policy (or clarification of policy [*sic*] having a basis in law and regulations may be generally known and applied by providers, intermediaries, and other interested parties.[52]

Moreover, the Board notes that Oswego is not located in the Eighth Circuit and, thus, the *Unity* decision is not binding precedent in this appeal.

Significantly, *subsequent to the time period at issue in this appeal*, CMS essentially adopted the Board's methodology for calculating VDA payments. In the preamble to the FFY 2018 IPPS Final Rule,[53] CMS prospectively changed the methodology for calculating the VDA to one which is very similar to the methodology used by the Board. Under this new methodology, CMS requires Medicare contractors to compare the estimated portion of the DRG payment that is related to fixed costs, to the hospital's fixed costs, when determining the amount of the VDA payment.[54] The preamble to the FFY 2018 IPPS Final Rule makes this change effective for cost reporting periods beginning on or after October 1, 2017, explaining that it will "remove any conceivable possibility that a hospital that qualifies for the volume decrease adjustment could ever be less than fully compensated for fixed costs as a result of the application of the adjustment."[55]

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[50] *Fairbanks Mem'l Hosp. v. Wisconsin Physicians Servs.*, Adm'r Dec. at 8 (Aug. 5, 2015), *modifying*, PRRB Dec. No. 2015-D11 (June 9, 2015).
[51] *Unity HealthCare v. Azar*, 918 F.3d 571,579 (8th Cir.), cert. denied, 140 S. Ct. 523, 205 L. Ed. 2d 335 (2019).
[52] (Bold and italics emphasis added.)
[53] 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).
[54] This amount continues to be subject to the cap specified in 42 C.F.R. § 412.92(e).
[55] 82 Fed. Reg. at 38180.

Pursuant to 42 C.F.R. § 405.1867, the Board must give great weight to interpretive rules and general statements of policy. As explained below, the Board finds that the Medicare Contractor's calculation of Oswego's VDA methodology for FY 2011 was incorrect because it was *not* based on CMS' stated policy as delineated in PRM 15-1 § 2810.1 and the Secretary's endorsement of this policy in the preambles to the relevant Final Rules.

The Medicare Contractor determined Oswego's VDA payment by comparing its FY 2011 fixed costs to its total FY 2011 DRG payments. However, neither the language nor the examples[56] in PRM 15-1 compare only the hospital's fixed costs to its total DRG payments when calculating a hospital's VDA payment. Similar to the instructions in PRM 15-1, the preambles to both the FFY 2007 IPPS Final Rule[57] and the FFY 2009 IPPS Final Rule[58] reduce the hospital's cost only by excess staffing (not variable costs) when computing the VDA. Specifically, both of these preambles state:

> [T]he adjustment amount is determined by subtracting the second year's MS-DRG payment from the lesser of: (a) The second year's cost minus any adjustment for excess staff; or (b) the previous year's costs multiplied by the appropriate IPPS update factor minus any adjustment for excess staff. The SCH or MDH receives the difference in a lump-sum payment.

It is clear from the preambles to these Final Rules that the only permissible adjustment to the hospital's cost for calculating the VDA is for excess staffing. Therefore, the Board finds that the Medicare Contractor did not calculate Oswego's VDA using the methodology laid out by CMS in PRM 15-1 or the Secretary in the preambles to the FFY 2007 and 2009 IPPS Final Rules.

Rather, the Board finds the Medicare Contractor calculated Oswego's FY 2011 VDA based on an otherwise *new* methodology that the Administrator adopted through adjudication in her decisions described as follows: the "VDA [payment] is equal to the difference between its fixed and semi-fixed costs and its DRG payment . . . subject to the ceiling[.]"[59] The Board suspects that the Administrator developed this new methodology using fixed costs because of a seeming conflict between the methodology explained in the FFY 2007 and 2009 IPPS Final Rules/PRM and the statute. Notably, in applying this new methodology through adjudication, CMS did not otherwise alter its written policy statements in either the PRM or Federal Register until it issued the FFY 2018 IPPS Final Rule.[60]

The statute at 42 U.S.C. § 1395ww(d)(5)(D)(ii) is intended to fully compensate the hospital for its fixed cost:

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[56] PRM 15-1 § 2810.1(C)-(D).
[57] 71 Fed. Reg. 47869, 48056 (Aug. 18, 2006).
[58] 73 Fed. Reg. 48434, 48631.
[59] *Lakes Reg'l Healthcare v. BlueCross BlueShield Ass'n*, Adm. Dec. 2014-D16 at 8 (Sep. 4, 2014).; *Unity Healthcare v. BlueCross BlueShield Ass'n*, Adm. Dec. 2014-D15 at 8 (Sep. 4, 2014); *Trinity Reg'l. Med. Ctr. v. Wisconsin Physician Servs.*, Adm. Dec. 2017-D1 at 12 (Feb. 9, 2017).
[60] 82 Fed. Reg. at 38179-38183.

> In the case of a sole community hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts under this subsection (other than under paragraph (9)) as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.[61]

In the final rule published on September 1, 1983 ("FFY 1984 IPPS Final Rule"), the Secretary further explained the purpose of the VDA payment: "[t]he statute requires that the [VDA] payment adjustment be made to compensate the hospital for the fixed costs it incurs in the period . . . . An adjustment will *not* be made for truly variable costs, such as food and laundry services."[62] However, the VDA payment methodology as explained in the FFY 2007 and 2009 IPPS Final Rules and PRM 15-1 § 2810.1 compares a hospital's total cost (reduced for excess staffing) to the hospital's *total* DRG payments and states in pertinent part:

> C. Requesting Additional Payments.—. . . .
>
> 4. Cost Data.—The hospital's request must include cost reports for the cost reporting period in question and the immediately preceding period. The submittal must demonstrate that the Total Program Inpatient Operating Cost, excluding *pass-through costs, exceeds DRG payments*, including outlier payments. *No adjustment is allowed if DRG payments exceeded program inpatient operating cost. . . .*
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> D. Determination on Requests.— . . . . The payment adjustment is calculated under the same assumption used to evaluate core staff, i.e. *the hospital is assumed to have budgeted based on prior year utilization and to have had insufficient time in the year in which the volume decrease occurred to make significant reductions in cost*. Therefore, the adjustment allows an increase in cost up to the prior year's total Program Inpatient Operating Cost (excluding pass-through costs), increased by the PPS update factor.
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> EXAMPLE A: Hospital C has justified an adjustment to its DRG payment for its FYE September 30, 1987. . . . Since Hospital C's FY 1987 Program Inpatient Operating Cost was less than that of FY 1986 increased by the PPS update factor, *its adjustment is the entire difference between FY 1987 Program Inpatient Operating Cost* ***and FY 1987 DRG payments***.

[61] (Emphasis added.)
[62] 48 Fed. Reg. 39752, 39781-39782 (Sept. 1, 1983) (emphasis added).

> EXAMPLE B: Hospital D has justified an adjustment to its DRG payment for its FYE December 31, 1988. . . . Hospital D's FY 1988 Program Inpatient Operating Cost exceeded that of FY 1987 increased by the PPS update factor, so *the adjustment is the difference between FY 1987 cost adjusted by the update factor* ***and FY 1988 DRG payments***.[63]

At first blush, this would appear to conflict with the statute and the FFY 1984 IPPS Final Rule which limit the VDA to fixed costs. The Board believes that the Administrator tried to resolve this seeming conflict by establishing a new methodology, through adjudication in the Administrator decisions, stating that the "VDA is equal to the difference between its *fixed and semi-fixed costs* and its DRG payment . . . subject to the ceiling."[64] Based on its review of the statute, regulations, PRM 15-1 and the Eighth Circuit's decision, the Board respectfully disagrees that the Administrator's methodology complies with the statutory mandate to "fully compensate the hospital for the fixed costs it incurs."[65]

Using the Administrator's rationale, a hospital is fully compensated for its fixed costs when the total DRG payments issued to that hospital are equal to or greater than its fixed costs. This assumes that the entire DRG payment is payment ***only*** *for the* ***fixed*** *costs* of the services actually furnished to Medicare patients. However, the statute at 42 U.S.C. § 1395ww(a)(4) makes it clear that a DRG payment includes payment for both fixed *and* variable costs of the services rendered because it defines operating costs of inpatient services as "**all** routine operating costs . . . and includes the ***costs*** *of all services* for which payment may be made[.]" The Administrator cannot simply ignore 42 U.S.C. § 1395ww(a)(4) and deem all of a hospital's DRG payments as payments solely for the fixed cost of the Medicare services actually rendered when the hospital, in fact, incurred both fixed and variable costs for those services.

Indeed, the Board must conclude that the purpose of the VDA payment is to compensate an SCH for all the fixed costs associated with the qualifying volume decrease (which must be 5 percent or more). This is in keeping with the assumption stated in PRM 15-1 § 2810.1(D) that "the hospital is assumed to have budgeted based on prior year utilization and to have had insufficient time in the year in which the volume decrease occurred to make significant reductions in cost." This approach is also consistent with the directive in 42 C.F.R. § 412.92(e)(3)(i)(A) that the Medicare contractor "considers . . . [t]he individual hospital's needs and circumstances" when determining the payment amount.[66] Clearly, when a hospital experiences a decrease in volume, the hospital should reduce its variable costs associated with the volume loss, but the hospital will always have some variable costs related to furnishing Medicare services to its *actual* patient load.

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[63] (Emphasis added.)
[64] *St. Anthony Reg'l Hosp.*, Adm'r Dec. at 13; *Trinity Reg'l Med. Ctr.*, Adm'r Dec. at 12.
[65] 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[66] The Board recognizes that 42 C.F.R. § 412.92(e)(3)(i)(B) instructs the Medicare contractor to "consider[]" fixed and semifixed costs for determining the VDA payment amount but this instruction does not prevent payment through the DRG of the variable costs for those services *actually* rendered.

Critical to the proper application of the statute, regulation and PRM provisions related to the VDA, are the unequivocal facts that: (1) the Medicare patients to which a provider furnished *actual* services in the current year are not part of the volume decrease, and (2) the DRG payments made to the hospital for services furnished to Medicare patients in the current year are payments for *both* the fixed and variable costs of the *actual* services furnished to those patients. Therefore, in order to fully compensate a hospital for its fixed costs in the current year, the hospital must receive a payment for the variable costs related to its *actual* Medicare patient load in the current year, as well as its full fixed costs in that year.

The Administrator's methodology clearly does not do this, as it takes the portion of the DRG payment intended for variable costs incurred in the current year and impermissibly characterizes it as payment for the hospital's fixed costs. The Board can find no basis in 42 U.S.C. § 1395ww(d)(5)(D)(ii) allowing the Secretary to ignore 42 U.S.C. § 1395ww(a)(4) – which makes it clear that the DRG payment is payment for both fixed and variable costs - and deem the entire DRG payment as payment solely for fixed costs. The Board concludes that the Administrator's methodology does not ensure that a hospital, eligible for a VDA adjustment, has been fully compensated for its fixed costs and, therefore, is not a reasonable interpretation of the statute.

Finally, the Board recognizes that, while PRM 15-1 § 2810.1 and 42 U.S.C. § 1395ww(d)(5)(D)(ii) do not fully address how to remove variable costs when calculating a VDA adjustment, it is clear that the VDA payment is *not* intended to fully compensate the hospital for its variable costs.[67] Additionally, based on 42 U.S.C. § 1395ww(a)(4), the Board finds that DRG payments are intended to pay for both variable and fixed costs for Medicare services *actually* furnished. The Board concludes that, in order to ensure the hospital is fully compensated for its fixed costs and be consistent with the PRM 15-1 assumption that "the hospital is assumed to have budgeted based on the prior year utilization," the VDA calculation must compare the hospital's fixed costs to that portion of the hospital's DRG payments attributable to fixed costs.

As the Board does not have the IPPS actuarial data to determine the split between fixed and variable costs related to a DRG payment, the Board opts to use the Medicare Contractor's fixed/variable cost percentages as a proxy. In this case, the Medicare Contractor determined that Oswego's fixed costs (which includes semi-fixed costs) were 91.30 percent[68] of Oswego's Medicare costs for FY 2011. Applying the rationale described above, the Board finds the VDA in this case should be calculated as follows:

Step 1: Calculation of the CAP

2010 Medicare Inpatient Operating Costs	$16,384,752[69]
Multiplied by the 2011 IPPS update factor	1.0235[70]

[67] 48 Fed. Reg. at 39782.
[68] Stipulations at ¶ 21.
[69] *Id.*.
[70] *Id.*

2010 Updated Costs (max allowed)	$16,769,794
2011 Medicare Inpatient Operating Costs	$15,682,265[71]
Lower of 2010 Updated Costs or 2011 Costs	$15,682,265
Less 2011 IPPS payment	$13,155,990[72]
2011 Payment CAP	$ 2,526,275

Step 2: Calculation of VDA

2011 Medicare Inpatient Fixed Operating Costs - Fixed portion (91.30 percent)	$14,317,908[73]
Less 2011 IPPS payment – fixed portion (91.30 percent[74])	$12,011,419 [75]
Payment adjustment amount (subject to CAP)	$ 2,306,489

Since the payment adjustment amount of $2,306,489 is less than the CAP of $2,526,275, the Board concludes that Oswego's VDA payment for FY 2011 should be $2,306,489. Since Oswego already received a VDA payment in the amount of $1,162,276[76], Oswego should receive an additional VDA payment in the amount of $1,144,21 for FY 2011.

DECISION

After considering the Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor properly reopened the Original VDA approval but improperly recalculated the Oswego's VDA payment for FY 2011, and that Oswego should receive an additional $1,144,213, for a total VDA payment in the amount of $2,306,489 for FY 2011.

Board Members Participating:

Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.
Kevin D. Smith, CPA

For the Board:

7/29/2021

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

[71] Stipulations at ¶ 21.
[72] *Id*.
[73] The $14,317,908 is calculated by multiplying $15,682,265 by the fixed portion percent of 91.30.
[74] Stipulations at ¶ 21.
[75] The $12,011,4199 is calculated by multiplying $13,155,990 by the fixed portion percent of 91.30.
[76] Stipulations at ¶ 13.